The End of the Beginning: Patient Safety Five Years After *To Err Is Human*

Earlier this month, the Commonwealth Fund Quality Improvement Colloquium marked the fifth anniversary since the publication of the Institute of Medicine's seminal report, *To Err Is Human.* Click here to view webcasts, transcripts, and presentations from the event.

Five years ago, the Institute of Medicine (IOM) galvanized the U.S. public and medical community with *To Err is Human,* its report on medical errors. The report's now-famous finding, that 44,000 to 98,000 Americans die each year as a result of medical mistakes, spawned intense media scrutiny and a flurry of congressional hearings—as well as heightened anxiety among many Americans.

Since the paper's publication in 1999, there has been some, but not sufficient, progress in making health care safer, says Robert Wachter, M.D., professor of medicine and chief of the medical service, University of California San Francisco Medical Center. In The End of the Beginning: Patient Safety Five Years After To Err Is Human" (*Health Affairs* Web Exclusive, Nov. 30, 2004), Wachter, a leading authority on medical errors and author of the book *Internal Bleeding,* assesses the scope of the problem, the impact of the IOM report, and the advancements of the past five years. "At this point, I would give our efforts an overall grade of C+, with striking areas of progress tempered by clear opportunities for improvement," Wachter says.

How Did Health Care Become So Unsafe?
The problem of medical errors has swelled, as technological and medical progress has created a far more specialized, complex environment, both within and outside the hospital, Wachter says. For example, a patient in intensive care may receive hundreds of tests and medications and be seen by dozens of physician and non-physician providers each day. The following forces limit the medical profession's ability to create a system in which patients can feel secure that they will not be harmed by medical mistakes: a mental model focused more on individual blame than system safety, a reimbursement system that provides no incentives for error reduction, and a structure that often separates physicians from the hospitals in which they practice.

Are We Making Progress?
In an informal survey of practicing hospitalists (i.e., physicians specializing in hospital inpatient care), Wachter found the majority of the group (55%) felt their hospitals had a "culture of safety," with nearly one-half attributing improvements to an overall increase in sensitivity to the issue. To assess progress made to date, Wachter categorized and graded the five major areas related to advancements in patient safety: regulation, error reporting systems, information technology, the malpractice system and other vehicles for accountability, and workforce and training issues.

Regulation: A–. Wachter agrees with many hospital leaders who view the Joint Commission on Accreditation of Healthcare Organization (JCAHO) as the most important driver of progress in patient safety. In a health system in which physicians

remain highly individualistic and hospitals continue to lack robust financial incentives, regulatory solutions have been the most important early step. Many of these have been common-sense measures; for example, requiring read-backs of patient names and oral orders to improve communications and standardizing the marking of body parts prior to surgeries. While additional regulation is likely, other drivers will become increasingly important, Wachter says.

Error reporting systems: C. Error-reporting systems can be powerful tools, but the results must be used to improve systems or educate providers. They can be particularly valuable when the individuals who submit reports learn that their submissions made a difference. However, many states and hospitals point with pride to growing numbers of error reports as evidence of improved safety, despite the lack of any organized programs to follow up on reports and turn them into meaningful changes. To translate data into action, new models and greater resources are needed.

Information technology: B–. There has been a marked uptick in implementation of clinical information systems, with many good results. There have also been reports of problems, from IT system crashes, to faulty systems that actually introduce errors, to physicians rebelling against computer interfaces that are not user-friendly. While the issue is clearly important to the federal government—as evidenced by the appointment of David Brailer, M.D., as National Health Information Technology Coordinator— hospitals must understand that patient safety is not synonymous with clinical IT, particularly if process change, standardization, and cultural issues are left unaddressed.

The malpractice system and other vehicles for accountability: D+. The malpractice system is broken, Wachter says, but its impact on patient safety, both positive and negative, has been overstated. The lack of accountability for poor performance is of greater importance. While Wachter supports the IOM-recommended shift from individual blame to systems improvement, a safe system must also deal effectively with bad doctors and nurses or with providers who willfully violate reasonable safety rules. This issue raises exceedingly complex questions for providers, patients, and institutions, Wachter says, and few solutions have been offered. "I believe we have made virtually no progress in tackling these exceptionally thorny questions in the past five years," he writes.

Workforce and training issues: B. In the inpatient arena, an important development has been the advent of hospitalists, who specialize in coordinating care and focus on patient safety. The national nursing shortage, however, has presented a challenge. In the ambulatory arena, a growing issue is the demor-alization of many primary care doctors and a resulting absence of leadership on safety. Efforts have been made to en-force limits on residents' duty hours, a reform that will ultimately improve safety by decreasing fatigue. In addition, more specialty medical boards are now requiring periodic recertification. However, two training strategies that received much attention after the IOM report—teamwork and simulation—have been largely neglected, despite their potential to improve performance and create a safer, more collaborative culture.

Conclusion
Wachter believes that overall efforts to improve patient safety earn a grade of only C+,

primarily owing to missed opportunities. Institutions are still generally underinvested in patient safety. The federal government's investment in safety through the Agency for Healthcare Research and Quality, for example, is about 1/500th of its general medical research investment, as reflected in the budget of the National Institutes of Health. Going forward, the right mix of financial, education, research, regulatory, organizational, and cultural activities will be needed to make health care significantly safer.

Federal Funding: Safety vs. Innovation

Millions of dollars
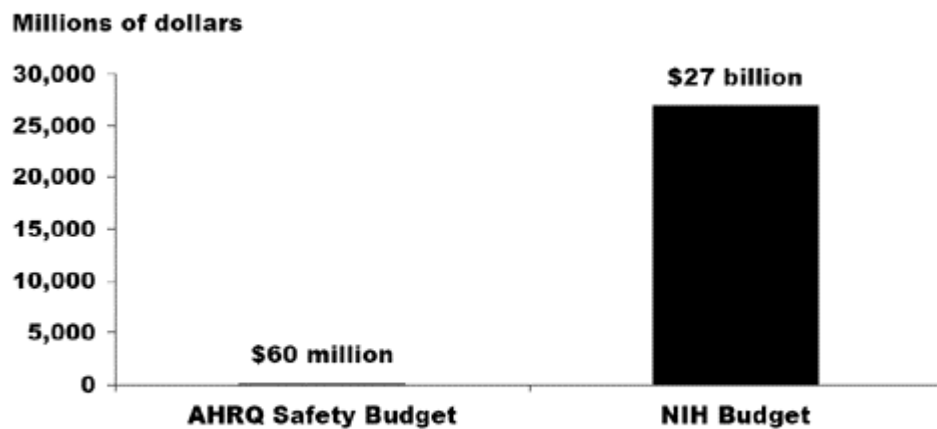
Notes: AHRQ = Agency for Healthcare Research and Quality; NIH = National Institutes of Health.
Source: R. M. Wachter and K. G. Shojania, *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes* (New York: Rugged Land Press, 2004).

Citation

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